STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 07/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGBROOK NURSING & REHABILITATION CENTER	195 SPRINGBROOK AVENUE CLAYTON, NC 27520

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F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation on 7/13/2018. Event I/D #H8JO11. Intakes NC00135223.NC00137460. NC00137928.	F 000		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must	F 690		8/2/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 07/26/2018

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F 690	Continued From page 1 ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review and resident, family and staff interview the facility failed to remove the end cap from a urinary catheter drainage bag when changing from a leg collection bag to a regular drainage bag, which prevented urine from draining in the bag for approximately 8 hours for 1 of 1 residents reviewed for urinary catheters (Resident #62). Findings included: Record review revealed resident #62 was admitted to the facility on 5/18/2018 with diagnoses which included urinary retention. The 5-day Admission Minimum Data Set (MDS) dated 5/25/2018 indicated Resident #62 was cognitively intact and required limited to extensive assistance of 1 to 2 persons for all his activities of daily living. The MDS also indicated the resident had an indwelling urinary catheter. Review of the Care Area Assessment (CAA) dated 5/25/2018 revealed Resident #62 had a history of issues with catheter tubing patency which required the tubing to be irrigated. The CAA indicated the resident was at risk for urinary tract infections due to urinary retention and the indwelling urinary catheter. The CAA indicated the area would be care planned. Review of Resident #62's care plan dated 5/25/2018 revealed a focus of an altered pattern of urinary elimination which required an indwelling	F 690	F 690 Bowel/Bladder Incontinence, Catheter, UTI CFR(s):486.25€(1)-(3) The process that led to this deficiency is that the facility failed to remove the end cap from a urinary catheter drainage bag when changing from a leg collection bag to a regular drainage bag, which prevented urine from draining in the bag for approximately 8 hours for 1 of 1 residents reviewed for urinary catheters (Resident #62). Upon assessment on 07/12/18 at approximately 5:00am, the nurse for resident #62 opened the catheter cap for resident #62. The Resident representative (RR) was present and aware of catheter cap removal. On 7/12/18 the physician was notified and examined resident #62 with no new orders. A 100% audit was completed on 7/12/18 by the Treatment Nurse and Quality Improvement (QI) Nurse of all patients with catheters to ensure catheter caps were in the appropriate position. A 100% in-service was initiated on 07/12/18 by the Director of Nursing (DON)	

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F 690	Continued From page 2 urinary catheter. The interventions included the resident would be free from complications form the indwelling urinary catheter and to maintain a closed drainage system with an unobstructed urine flow. An interview was conducted with Resident #62 on 7/12/2018 at 10:05 AM. The resident's family member was visiting the resident. The resident reported the urinary catheter leg bag was changed by Nursing Assistant (NA) #1 to the large collection bag the night before at approximately 8:00 PM. The resident stated he woke up around 5:00 AM and felt like his bladder was full. The resident indicated he did not experience any pain. The resident further indicated there were times the catheter tubing would become clogged and would have to be irrigated. The resident stated he called for the nurse and she immediately came to the room. He stated he informed her of how he felt and she assessed the catheter tubing and the collection bag. He stated she disconnected the collection bag, removed the little blue cap on the end of the tubing and reconnected the collection bag. He reported when the collection bag was reconnected the urine flowed into the tubing and the collection bag. The resident stated there were no further issues with the catheter. The resident removed the privacy cover form the urinary collection bag and approximately 200 milliliters of clear yellow urine was observed in the bag. An interview was conducted on 7/12/2018 at 3:16 PM with Nursing Assistant (NA) #1. NA #1 confirmed she was the NA who changed the urinary catheter leg bag to the large drainage bag for Resident #62 on 7/11/2018. NA #1 reported she was unsure of the exact time but thought it	F 690	to be conducted by the DON, Assistant Director of Nursing (ADON), Staff Facilitator, Treatment Nurse, and/or QI Nurse with all licensed personnel to educate staff that facility practice would be for nurses only to change catheter systems. Furthermore, in-servicing will educate that the entire system should be changed unless otherwise indicated to lessen the likelihood of cap error. In-servicing will be completed on 07/27/18. All newly hired licensed personnel will be in-serviced by the Staff Facilitator in orientation in regards to facility practice for nurses only to change catheter systems, and that the entire system should be changed if possible to lessen the likelihood of cap error. 25% audit of Catheter System Replacement will be monitored using a Catheter Systems Replacement QI Tool to ensure cap position, and compliance with new facility practice by the ADON, Unit Manager, and QI nurses 3 times a week X's 4 weeks, then weekly X's 4 weeks then monthly X's 1 month. The licensed personnel will be immediately re-trained by the auditor for any identified areas of concern. The DON will review and initial the Catheter Systems Replacement QI Tool for completion to ensure all areas of concerns were addressed weekly X's 8 weeks and monthly X's 1 month. The Executive QI committee will meet to review the Catheter Systems Replacement QI tool monthly X's 3 months to determine issues and trend to	

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F 690	Continued From page 3 was after 8:00 PM. NA #1 reported the resident wanted to return to bed from his wheelchair and asked to have the small urinary drainage bag switched out to the large collection bag before he returned to bed. NA #1 indicated she emptied the urine from the small drainage leg bag, removed the small bag and replaced the bag with the large collection bag which was in the room and assisted the resident to bed. The NA indicated the resident's family member was in the room when the drainage bag was changed. The NA stated she did not recall if there was a blue cap on the large bag tubing when she attached it to the urinary catheter tubing. The NA reported she checked on the resident around 10:30 PM when she was completing her last round on her assignment. NA #1 indicated there was no urine in the collection bag at that time. NA #1 stated since she emptied the urine from the small leg bag after 8:00 PM prior to attaching the large collection bag there was no need for concern. NA #1 stated she did not notify the nurse. An interview was conducted with Nurse #1 on 7/12/2018 at 3:50 PM. Nurse #1 confirmed she was the nurse on duty for the Resident #62 on the 11PM to 7AM shift for 7/11/2018. Nurse #1 stated the resident called for her around 5:00 AM and stated he felt his bladder was full. Nurse #1 indicated the resident was alert and oriented and knew when there were issues with his bladder. The nurse stated she assessed the collection bag to see if his urine was normal and noticed there was no urine in the collection bag. The nurse stated she checked the tubing for patency and when she disconnected the tubing form the drainage system she noticed the blue end cap was on the tubing. She stated she removed the cap, reconnected the tubing and the urine began	F 690	include continued monitoring frequency.	

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F 690	Continued From page 4 to flow in the collection bag. The nurse stated she assessed the resident's vital signs and they were normal. The nurse stated the resident reported the feeling of pressure was gone and he had no other issues during the shift. The nurse stated the catheter drained approximately 600 milliliters of clear urine after the cap was removed. The nurse stated she reported the end cap was on the tubing when she assessed the resident to the Director of Nursing (DON) prior to leaving the facility that morning. An interview was conducted with the Director of Nursing (DON) on 7/12/2018 at 4:12 PM. The DON stated she was notified of the issue with the drainage collection bag that morning. The DON stated the expectation was for proper care be provided by all staff with indwelling urinary catheters and the tubing to ensure the tubing was patent and draining urine.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews and record review, the facility failed to provide respiratory care by not labeling or dating the oxygen tubing for one of one residents	F 695	F 695 Respiratory/ Tracheostomy Care and Suctioning CFR(s): 483.25(i)	8/2/18

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F 695	Continued From page 5 reviewed for respiratory care (Resident #62). Findings included: A review of the medical record revealed Resident #62 was admitted 5/18/2018 with diagnoses which included respiratory failure, urinary retention and aftercare following joint replacement surgery. The admission Minimum Data Set (MDS) dated 5/25/2018 noted Resident #62 to be cognitively intact and had no behaviors and had no rejection of care. The MDS noted Resident #62 needed extensive assistance for all Activities of Daily Living (ADLs) with the physical assistance of one to two persons. The care plan dated 7/2/2018 noted a focus of potential for ineffective breathing related to respiratory failure. The goal was airway maintained through next review. Interventions included oxygen therapy and monitoring for insufficient breathing pattern. Order noted for oxygen therapy at 2 liters per minute via nasal cannula. On 7/11/2018 at 11:00 AM an observation was made of Resident #62 in his room with oxygen in use and tubing connected to an oxygen concentrator. There was no label with a date on the tubing. Resident #62 stated he did not know when the tubing was last changed. An observation was made on 7/12/2018 at 10:00 AM of Resident #62 using the oxygen and the tubing was connected to the concentrator without a label and date. The Resident stated the tubing had not been changed since the day before. On 7/13/2018 at 10:50 AM, Resident #62 was ambulating in the hallway without his oxygen. Upon entering the room, the tubing was laying in the floor without a dated label on the tubing. In an interview on 7/13/2018 at 11:00 AM, the Director of Nursing (DON) stated oxygen tubing is	F 695	The process that led to this deficiency is that the facility failed to provide respiratory care by not labeling or dating the oxygen tubing for one of one residents reviewed for respiratory care (Resident #62). The oxygen tubing for patient #62 that was undated was discarded and replaced with new tubing and dated on 7/13/18. A 100% audit was completed on 7/13/18 by the Treatment Nurse and Quality Improvement (QI) Nurse for all patients using Oxygen to include resident #62 to ensure all tubing was accurately labeled and less than or equal to 7 days old. Any areas of concern were addressed at that time. A 100% in-service with all licensed nurses was initiated on 7/13/18 by the DON in regards to the requirements of dating Oxygen tubing and replacing tubing greater than 7 days old. In-service will be completed by 07/27/18. All newly hired licensed nurses will be in-serviced by the Staff Facilitator in regards to the requirements of replacing and dating oxygen tubing every 7 days during orientation. 25% audit of all oxygen tubing to include oxygen tubing for resident #62 will be completed by the Assistant Director of Nursing (ADON), Unit Manager, and QI nurses utilizing the Oxygen Tubing QI audit tool to ensure all tubing is accurately labeled and less than or equal to 7 days old 3 times a week X's 4 weeks, then	

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F 695	Continued From page 6 changed weekly by the central supply clerk and dated at that time. An observation was made, in the company of the DON, in Resident #62's room, of the oxygen tubing coiled on the floor. After inspecting the tubing the DON stated there was no date on the tubing. On 7/13/2018 at 11:30 AM, the central supply clerk was interviewed and stated she did not document when the tubing on residents' oxygen was changed. She stated every Wednesday she took the list of residents on oxygen and went around and changed all of the tubing. In an interview on 7/13/2018 at 11:45 AM, the DON stated her expectation was the oxygen tubing would be labeled and dated when it was changed.	F 695	weekly X's 4 weeks then monthly X's 1 month. The licensed nurses will be immediately re-trained by the auditor for any identified areas of concern. The DON will review and initial the Oxygen Tubing QI Tool for completion to ensure all areas of concerns were addressed weekly X's 8 weeks and monthly X's 1 month. The Executive QI committee will meet to review the Oxygen tubing QI tool monthly X's 3 months to determine issues and trend to include continued monitoring frequency.	